A review of Certificate of Need health care policy programs:

At the intersection of science and politics

Washington State CON Task Force

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Research about CON

- many conclusions state more than the research underlying them is competent to conclude.
- researchers of CON have often offered conclusions even if the data and research methodology were inadequate for the purpose.

There ARE Findings:

1. Neither CON nor competition models appear to have had much impact on the extreme increases in health care costs that have plagued the American economy since at least the 1960s.

- 2. There is evidence that CON has had <u>some</u> positive effects on hospital capital expenditures, mostly by encouraging more planning, by having a sentinel effect on growth, and by slowing down some expansion plans and duplication of services.

- 3. The traditional “market failure” and “public good” characteristics of health care that served as the rationale for regulation still exist:
  - a. the social goal (and legal requirement) of care being provided regardless of ability to pay
  - b. demand largely being determined by the same party that supplies the services
  - c. guaranteed payment for almost all the services providers can provide.
  - d. lack of effective competition in many markets, either through natural factors such as geography, regulatory factors such as CON, or predatory market practices such as anti-competitive mergers and other cartel behaviors

- e. hospitals not competing based on price, but rather competing for the allegiance of doctors by increasing facilities, adding equipment, paying larger salaries, and instituting prestigious programs such as heart surgery
- f. there is evidence that when hospitals lose business to competition, either other hospitals or ambulatory surgery or diagnostic centers, they do not lower prices. Rather, they raise prices on the other services the hospitals still provide and for which they still have a monopoly in the market
- g. consumers have little ability to influence whether they need hospital services and generally do not comparison shop for hospital services when they do need hospital services

- h. most people have third-party reimbursement (either private insurance or government benefits) for their hospital expenses and are generally unaware of, and not responsible for, most of the cost of treatment
- i. one aspect of the system, the Medicare and Medicaid programs, can mitigate utilization and charges, but is only partially successful because providers are able to cost-shift (charge more than cost plus reasonable profit) to other payers, especially insurance companies
- j. the primary impact of market failure and public good features is a health care system that can basically be as big as it wants to be and be guaranteed that someone (either government programs or third-party insurance) will pay whatever charges it sets

- 4. The health care system is dominated by a paradigm that thwarts most attempts at cost control: this paradigm is the guaranteed, third-party payment to providers who influence demand and determine charges, and who have few incentives for price or cost competition.
- 5. One of the dominant conflicts in modern healthcare, particularly concerning hospitals, is between established hospitals trying to maintain monopoly power and entities such as ambulatory surgery centers that are trying to enter the market.

- 6. Two ideological schools, one labeled “pro-regulation” and one labeled “pro-competition” are locked in conflict over the future of health care, and virtually all health care policy issues, concepts, and proposals tend to be pre-judged based on which of these ideological camps the policy makers, researchers, professionals, or consumers identify with.
- 7. Neither an increased and more effective regulatory system nor a well-functioning competitive system are likely to occur in the foreseeable future. The former would require substantial control over providers and the latter would require destruction of current programs of guaranteed third-party payment, consumer protection, guaranteed issue, and equity mandates.

- 8. Realistically, the alternatives are:
- A. accept the current paradigm: that health care will continue to consume larger and larger shares of the gross domestic product and of state and federal budgets (already 20-25% of state budgets);
- B. make incremental progress, "bend the curve": making modest adjustments to regulations, encouraging more consumer involvement in health care decision-making about services and benefits, encouraging providers to be more efficient, encouraging healthy lifestyles and disease management programs, trying to change reimbursement mechanisms to pay providers more for prevention efforts and less for acute care, working to support continued financial health of insurance plans;

- c. experiment in several states with new funding and delivery models such as single-payer, mandated-insurance, reduced regulation, or new methods of introducing competition;
- d. replace the blank check health care financing system with a defined bank balance: find a mechanism to either set providers' rates or create annual budgets for providers and give them the freedom and responsibility to manage within those budgets.

Measuring CON's Effectiveness

- could look at the number of CON applications denied
- what if, especially some years after the CON program has been in place, some applications for capital expenditure are not submitted because the providers expect they will be denied?

- as providers learn what is likely to be approved and what is not, expect applications that suit the guidelines to dominate the number of applications submitted.

- the “sentinel effect” of CON - stopping capital projects before they become CON applications.
- measuring the success or failure of CON should not just look to the dollar amount of proposed projects approved and denied, but also to the long- term operating costs that flow out of capital projects undertaken.

- Likewise, CON opponents sometimes complain that proponents' claims of health care dollars saved through CON ignore the costs involved in participating in and complying with the CON process.

Effective Programs

- - compare methods for meeting a perceived need
- - ensure that lower cost alternatives are identified in order for comparisons to be made

- - have competitive reviews through a batching process.
- - engage in planning- don’t just be reactive
- - develop and maintain an independent viewpoint skeptical of providers’ claims

- ensure good staff work emphasizing the importance of cost controls and the need to demonstrate positive results for the population served

- - ensure the staff can provide a contrary point of view to the applicant
- - have non-applicant presentations

- - have secret balloting by the decision making body
- - Reviewers should “strive to make applicants show need in social terms – results for patients and populations – rather than in terms of medical process or institutional needs.”

- - make comparisons between providers as a proxy for quantitative standards
- - The burden of proof needs to be on the applicant

"Does CON Work?"

- "Several studies provide empirical evidence of extensive duplication of services and redundant hospital capacity in competitive markets. When cost-reimbursement policies provide easy financing of the associated cost, competition drives capacity up, because hospitals develop a full range of services to attract and retain medical staff and patients."

More on "Does CON Work?"

- In June of 2000, the Finger Lakes Health Systems Agency, based in Rochester, New York, published a study entitled "Capacity Matters." In its report, the agency provides a strong argument that Roemer's Effect is alive and well, at least in the Rochester area. The group concluded that there is substantial evidence that excess capacity leads to increased costs, under-utilized facilities and increased use of health care services.

- in the six years following repeal of CON in Pennsylvania, lithotriptor supply doubled, procedure volume per machine fell from 773 to 489, against a capacity of 1,000 to 2,000 per machine. Average operating cost per procedure in 1994 was estimated to be $2,107, but would have been only $1,331 if each machine were performing 1,000 procedures."
- Also, Pennsylvania's MRI capacity more than doubled and volume per machine dropped to between 60 and 75 % of state guidelines. Cardiac catheterization lab capacity increased 90% and the average volume fell from 1,034 to 758 per lab.

- An October, 2002 report in the Journal of the American Medical Association indicated that risk adjusted mortality was 22% higher in the 18 states that had no CON regulation for open heart surgery than in the 26 states (and D.C.) that had continuous CON regulations. The higher mortality was observed in all six years of the study
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Regulation, Deregulation, Regulation, Deregulation, …

- Texas, Tennessee, California and Virginia removed CON application to home health agency development in recent years. Tennessee reinstated it, however, after rapid growth in HHAs "threatened to destabilize the entire industry".

Regulation, Deregulation, Regulation, Deregulation, …

- Other states have imposed moratoria on issuance of new HHA CONs: Florida, Georgia, Alabama, Kentucky, and Mississippi. (prevalence of capitation as a payment source in home health).

Regulation, Deregulation, Regulation, Deregulation, …

- In Tennessee, a major change in the program involved how CON considered projects' potential effects on TennCare, Tennessee's health care insurance program for low-income people. The reform legislation mandated that the effects on TennCare be taken into consideration with every CON application.

More about Structural Problems

- Loopholes such as avoiding CON by leasing instead of purchasing .
- - Lack of competing applications
- - Political pressures, ex parte communications
- - Difficulty defining need
- - Difficulty evaluating new technologies
- - Ruling bodies lacking incentives to turn down applications:
- - Costs are spread across the system
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- - The “physician office” exemption that was intended to exempt the traditional, freestanding, independent doctor’s office from CON regulation but also allows large hospital-owned physician practices to escape review.
- - Providers have an incentive to push up their plans and be the first one to apply (except where applications are batched.
- - Sanctions are often lacking, ill-defined, inadequate, or counterproductive

- CON only addresses one part of the hospital cost pie. It does not limit non-capital expenses, the number of units of service provided, prices charged, staffing ratios, salaries, supplies and non-capital equipment, equipment below the thresholds, or utilization – the number of admissions, length of stay, procedures done, etc.

Finally

- There is consensus that there is a cost crisis in health care. There is no consensus on whether to address it through a regulatory approach, a competition approach, or some other method.
- The current structure of the health care system, the public good aspect of its purposes, and the need to assure quality make it impossible to have a completely unregulated system. If CON is to be used as a cost containment tool, however, its limitations must be acknowledged and it must be designed in such a way as to maximize its costs and benefits.
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